



# Office of Inspector General

## AUDIT OF INTERNAL CONTROLS OVER THE FEE-BASIS PROGRAM

*VHA can strengthen the fee-basis  
program by establishing management  
controls in its planned centralization  
of the payment process.*

**Report No.: 7R3-A05-099**

**Date: June 20, 1997**

Office of Inspector General  
Washington DC 20420



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington DC 20420**

**Memorandum to the Under Secretary for Health (10)**

**Audit of Internal Controls Over the Fee-Basis Program**

1. The Office of Inspector General has conducted a series of audits of the Veterans Health Administration's (VHA) fee-basis program. The purpose of this audit was to determine if VHA had established effective internal controls to reasonably ensure that fee-basis payments made were appropriate. During the period of our audit, April 1, 1994 through March 31, 1995, VHA paid \$237 million for fee-basis treatments provided to eligible beneficiaries, including \$112 million for outpatient care, \$94 million for inpatient care, and \$31 million for home health care.

2. The audit included a review of fee-basis payments made for a sample of 280 veteran patients at 5 VA facilities who received treatment during the period of our review. We also reviewed and analyzed nationwide computer matches of veterans' records, including veterans whose fee-basis treatment was paid through more than one VA facility, and veterans with a "date of death" in the Beneficiary Identification and Record Locator System and a subsequent fee-basis treatment date.

3. Overall, VHA's internal controls provided reasonable assurance that payments for fee-basis services were appropriate. However, we found that management controls could be improved by:

- Implementing procedures to ensure that two or more VA facilities did not pay for the same fee-basis service.
- Notifying veterans when VA paid for fee-basis medical care on their behalf.
- Improving procedures to prevent inappropriate payments for services allegedly provided after the veteran's death.
- Strengthening management oversight of the fee program.

4. VHA has a planned initiative to centralize authorizations and payments for fee-basis medical services starting with a pilot project in Veterans Integrated Service

Network (VISN) 19. We believe that this initiative would reduce or eliminate the control weaknesses identified during the audit.

5. Additionally, charges for home health care varied widely for comparable services, both from one medical center to another and within individual medical centers. We believe VHA could reduce expenditures by at least \$1.8 million annually for fee-basis home health care by encouraging medical centers to use formal contracting and by establishing benchmarks for reasonable rates.

6. The audit report contains recommendations to the Under Secretary for Health to:

- Ensure that management controls over the pilot project to consolidate fee-basis authorizations and payments in VISN 19 include provisions to (i) prevent duplicate payments, (ii) notify veterans of VA payments for medical care on their behalf, (iii) prevent inappropriate payments for services after the death of a veteran, (iv) conduct meaningful internal reviews, and (v) provide appropriate training for the staff.
- Establish guidelines for contracting for home health services and benchmarks for determining reasonable rates.

7. The Under Secretary for Health concurred with our findings and recommendations, our estimated cost efficiencies, and provided acceptable implementation plans. In addition to taking interim action at the VISN level to encourage the use of contracting for home health services, VHA also plans to include claims processing for these services in the pilot test being conducted in VISN 19, using a procedure-based payment methodology. Based on actions taken or planned, we consider all issues resolved. We will continue to follow up on the implementation of planned actions until they are completed.

For the Assistant Inspector General for Auditing

*(Original Signed By)*  
JAMES R. HUDSON  
Director, Operations Division

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## **RESULTS AND RECOMMENDATIONS**

### **1. Internal Controls Over the Fee-Basis Program Can Be Strengthened by Centralizing the Authorization and Payment Process**

Overall, internal controls provided reasonable assurance that payments for fee-basis services were appropriate. However, the audit identified opportunities for the Veterans Health Administration (VHA) to strengthen management controls to further reduce the risk of fraud, waste, or abuse by:

- Implementing procedures to ensure that two or more VA facilities do not pay for the same fee-basis service.
- Notifying veterans when VA pays for fee-basis medical care on their behalf.
- Strengthening procedures to prevent inappropriate payments for services for deceased veterans.
- Strengthening management oversight of the fee program.

VHA has a planned initiative to centralize authorizations and payments for fee-basis medical services starting with a pilot project in Veterans Integrated Service Network (VISN) 19. Authorizations for fee medical services would be processed through the individual VISNs, while payments would be processed through the Denver Health Administration Center (HAC). We believe that this initiative would further reduce or eliminate control weaknesses identified during the audit.

### **Payments for Fee-Basis Medical Services Exceeded \$230 Million Annually**

In instances when VA medical facilities are unable to provide specific treatment or cannot provide treatment economically due to geographic inaccessibility, certain veteran patients may be authorized to receive treatment from non-VA health care providers at VA expense. The program of providing such treatment is commonly referred to as the fee-basis program. Fee-basis care may be authorized for inpatient care at a non-VA hospital, outpatient care, and home health care.

During the 12-month period of our review, April 1, 1994 through March 31, 1995, VHA paid about \$237 million for fee-basis medical services, including \$112 million for outpatient services, \$94 million for inpatient services at non-VA hospitals, and \$31 million for home health services. Payments for fee-basis medical services were processed by 159 medical facilities<sup>1</sup>. Each facility was responsible for authorizing fee-basis care, processing medical bills, and approving payments. Each facility's

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<sup>1</sup> Includes facilities which processed only community nursing home payments.

decentralized hospital computer program (DHCP) included a fee-basis segment which interacted with the central FEE System in the Austin Automation Center (AC). The central FEE System at Austin processed payments through VA's Financial Management System.

### **Decentralized Fee Payments Had Control Weaknesses**

As a result of internal control weaknesses, some improper payments were made. The FEE System did not have the capability for one medical center to detect potential duplicate payments made by another medical center. The system sent notification letters to less than half of the veterans who received outpatient service and none who received inpatient care. In addition, there were no effective procedures to ensure that inappropriate payments were not made for services after a veteran's death. Because of the small size of the program at most individual medical centers, the processing of fee payments did not receive a high level of management attention, particularly those with low fee-basis expenditures.

**Procedures to ensure that several VA facilities did not pay for the same fee-basis service need to be established** - There were no controls in place to prevent duplicate payments to the same vendor for the same service by two or more medical centers. At three VA facilities we visited, payments for fee-basis services were duplicated by other medical centers:

- Six providers were paid by a VA health care system and two other nearby VA facilities for the same fee-basis services provided to six veterans. Total overpayments were \$13,500.
- Two providers received duplicate payments from a VA medical center and two other VA facilities for fee-basis services provided to four veterans. Total overpayments for the fee services were \$2,800.
- Twenty-three providers were paid by another VAMC and five other VA facilities for the same fee services provided to 24 veterans. Total overpayments were \$6,600.

The facilities that made the duplicate fee payments were not aware that another medical facility had already paid for the same service. Although the fee segment of the DHCP alerted fee staff to potential duplicate payments at an individual medical center, there was no interface with other medical centers. The central FEE System at the Austin AC did not notify fee personnel when another medical center had already paid for the same service. We requested medical center management at the facilities visited to take action to recover the overpayments.

**All veterans were not notified when VA paid for medical care** - Each month, the central FEE System at the Austin AC issued notification letters to certain veterans

stating that fee-basis payments had been made in their behalf. The notification letters showed the date of service, amount paid, and the provider. These letters are an important control to ensure the service is actually provided and no other “payers” (e.g., the veteran, Medicare, or private insurance) are involved.

However, notification letters were not sent to most veterans. No letters were sent to the 12,000 veterans who received \$94 million in inpatient care from non-VA facilities, including hospital, physician, and ancillary services. Letters were sent only to fee-basis outpatients with long-term health care authorizations entered into the FEE System. Notification letters were sent for treatment costing \$56 million, which represented only 39 percent of the \$143 million in payments for outpatient treatment and home health care. Excluding veterans whose only fee-basis treatment was a compensation and pension examination, only 46 percent of outpatients had long-term authorizations and thus, routinely received notification letters. By limiting the distribution of notification letters, VHA reduced the usefulness of a very valuable internal control.

**Procedures to prevent inappropriate payments for services allegedly provided after the veteran’s death need to be improved** - We identified 165 fee-basis payments made for services after a veteran’s date of death was recorded in the Beneficiary Identification and Locator System (BIRLS). We found that 11 overpayments totaling \$496 were made to fee-basis providers for services allegedly provided after the veteran’s death.<sup>2</sup> Common problems included fee-basis payments made to providers for a “no show” for a scheduled visit or for care in a community nursing home after the veteran’s death. Although there was a cross-match of BIRLS and the central FEE System at the Austin AC, the match was only made with veterans who had long-term fee-basis authorizations in the system.

**The fee program did not receive close management attention** - The management of the fee-basis program is decentralized to 159 medical centers. Although the fee-basis program is large nationally, with over \$230 million in payments annually, the program is relatively small at many facilities. Only 54 facilities had outpatient treatment payments in excess of \$1 million annually, and of those, only 20 had payments in excess of \$2 million. As a result of decentralizing the payment system to the individual medical centers, those with relatively low fee-basis activity have not placed a high level of management attention on the program. Fee section employees at the individual facilities were generally not trained in medical coding or recognition of fraudulent or erroneous billings. At some of the smaller facilities, the fee program staff was too small to allow for adequate segregation of duties. Medical centers seldom performed any significant internal reviews of the fee-basis program.

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<sup>2</sup> The remaining cases not involving overpayments included inaccurate dates of death in BIRLS, inaccurate dates of service in the FEE System, and competency examinations for widows of deceased veterans paid under the veterans’ name.

## **Centralized Fee Authorizations and Payments Would Strengthen Internal Controls**

VHA has a planned initiative to centralize authorizations and payments for fee-basis medical services starting with a pilot project in VISN 19. Under the proposed system, authorizations would be processed through individual VISNs and the actual payments would be processed through the Denver HAC. The Denver HAC is currently responsible for processing all payments for veterans' dependents covered under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

If properly implemented, consolidating authorizations for fee medical services in each VISN and processing all payments through the Denver HAC would eliminate or reduce control weaknesses identified during the audit. The proposed system would identify and help eliminate duplicate payments by multiple medical centers, since all payments would be made through the Denver HAC. The proposed system would send notification of treatment letters to every veteran receiving services and would have an effective interface with BIRLS. Payments for fee services would receive greater management attention, since the primary function of the Denver HAC is processing payments for medical services.

The Consolidated Fee Task Force, which developed the proposal, estimated that savings would be approximately \$20 million annually once centralization was achieved nationwide. The savings would be achieved by:

- Better allocation of VA resources by consolidating the authorization process at the VISN level. Before fee-basis services are authorized, all medical services offered within the VISN would be considered, not just the resources of an individual medical center.
- Reduction in improper payments to providers by use of sophisticated computer programs and quality management staff to detect fraud and billing errors.
- Reduced number of staff through economy of scale and increased automation at the Denver HAC.



We also believe that the savings gained through consolidation would be significant. We endorse the planned pilot project for both the cost savings and improved management controls. The proposal for a pilot project in VISN 19 has been approved by the Under Secretary for Health, but not yet funded. According to management at the Denver HAC, funding for the pilot project is expected shortly.

### **For More Information**

- *Detailed information about the audit scope and methodology is provided in APPENDIX I.*
- *Background information is provided in APPENDIX II.*

### **Conclusion**

Overall, internal controls provided reasonable assurance that payments for fee-basis services were appropriate. However, the audit identified opportunities to further strengthen management controls over payments. Because payments were decentralized to 159 medical facilities, a high level of management attention was not found at many medical centers, particularly those with low fee-basis expenditures. Centralization of fee-basis authorizations and payments would result in improved internal controls. Without consolidation, it would be difficult to correct the internal control weaknesses noted during the audit at each of the 156 medical centers that process fee-basis payments. We agree with VHA's task force that significant reductions in expenditures would be achieved through (i) better use of resources within each VISN, (ii) economies of scale in processing payments, and (iii) improved detection of improper billings.

### **Recommendation 1**

We recommend that the Under Secretary for Health ensure that management controls over the pilot project to consolidate fee-basis authorizations and payments in VISN 19 contain provisions to (i) prevent duplicate payments, (ii) notify veterans of VA payments for medical care on their behalf, (iii) prevent inappropriate payments for services provided after the death of a veteran, (iv) conduct meaningful internal reviews, and (v) provide appropriate training for the staff.

### **Under Secretary for Health Comments**

The Under Secretary for Health concurred with the findings and recommendations.

## **Implementation Plan**

The Under Secretary provided implementation plans which state that actions will be implemented by October 1997, and will be ongoing. According to the Under Secretary's comments, controls have been, or will be built-in to the pilot program to i) prevent duplicate payments, ii) provide explanations of benefits, and iii) prevent inappropriate payments for services after a veteran's death. According to the Under Secretary, the NAC has established comprehensive internal review procedures and the new software contractor will provide extensive training on the use of the software and internal control capabilities. The NAC has extensive training courses in place that will complement the new Network 19 Authorization Office system. Cross-training for key personnel will be conducted by both Centers. The Under Secretary recognized that the issues identified in the audit must also be dealt with on an interim basis by those facilities not participating in the pilot. According to the Under Secretary, action will be taken to address the administrative problems identified through adjustments in existing software. *(See APPENDIX III for the full text of the Under Secretary's comments.)*

## **Office of Inspector General Comments**

The Under Secretary's comments and implementation plan are acceptable and we consider all issues resolved. We will follow up on the implementation of planned actions until they have been completed.

## **2. Medical Centers Can Reduce Expenses for Fee-Basis Home Health Care Through Negotiated Contracts**

Charges for home health care varied widely for comparable services, both from one medical center to another and within individual medical centers. We believe VHA could significantly reduce expenditures for fee-basis home health care by encouraging medical centers to use formal contracting and by providing comparative cost data to set benchmarks for reasonable rates. Some medical centers have already achieved substantial savings from formal contracting and many others could achieve similar savings. We estimate that VHA could reduce expenditures by at least \$1.8 million annually through more effective use of contracting.

### **Expenditures for Home Services Exceed \$30 Million Annually**

During the period of our review, April 1, 1994 through March 31, 1995, VHA paid approximately \$31 million for fee-basis health services provided in veterans' homes. Of this amount, \$20 million was spent for 284,000 visits for skilled nursing services, at an average cost of \$70 a visit. An additional \$10.4 million was spent for 186,000 visits from an aide or non-nursing personnel, at an average cost of \$56 per visit.

The most common types of fee-basis care provided in veterans' homes are Fee-Basis Home Health Services (FBHHS) and Homemaker/Home Health Aide Services (H/HHAS). FBHHS are medical services provided under the direction of a physician and include such services as catheter irrigation, colostomy bag changes, changing dressings, medication administration, and assistance with prosthetic devices. They may be provided by either a nurse or an aide, depending on the level of skill needed. H/HHAS provide personal care in lieu of nursing home care and can include meal preparation, assistance in bathing and dressing, and other activities of daily living. H/HHAS are generally provided by non-nursing personnel.

### **Costs for Comparable Services Vary Widely**

VHA had not established guidelines for contracting or benchmarks for reasonable charges for home health or homemaker services. As a result, comparative data about costs within VA or prevailing rates outside VA was not available to facility management. Therefore, rates paid for comparable fee services varied widely.

Nationwide, VHA paid an average of \$70 for a home health visit by a nurse during the period of our review. We analyzed the payments from the 46 medical centers that paid for more than 1,500 home health visits by nurses during this period. Costs at these sites varied from a low of \$40 per visit at one VAMC, to a high of \$230 a visit at another VAMC. Costs also varied widely at individual medical centers. For example, at one VAMC, approximately 1,000 nursing visits cost less than \$50, about 3,300 visits cost between \$50 and \$100, and over 1,000 cost more than \$100 a visit.

Even allowing for the possibility of some discrepancies in coding, these figures show an excellent potential for cost control.

For in-home services provided by non-nursing personnel, VHA paid an average of \$56 during the period of our review. Payments also varied widely for non-nursing services from a high of \$96, to less than \$30 a visit.

### **Negotiated Contracts Can Significantly Reduce Costs**

VHA did not provide guidance for contracting for home health services and, consequently, many medical centers did not have formal contracts for home health services. However, some medical centers have achieved substantial reductions in rates. For example, one VAMC had been paying an average of \$96 per visit for nursing services. In order to reduce costs, medical center management used competitive contracting for fiscal year 1996. The medical center awarded a contract to the lowest of seven responsive bidders for \$67 per visit for all skilled nursing services. This resulted in a \$28 (29 percent) reduction in the cost of a nursing visit. Since the medical center pays for about 2,300 nursing visits annually, the center's savings will be about \$66,000 each year.

We believe that other medical centers could also realize significant cost savings from negotiated contracts. One VAMC paid for about 7,000 skilled nursing visits provided annually by the State Department of Health and Environmental Services (DHES). The medical center paid \$85 a visit, while Medicare paid DHES only \$73 for the same services. As a result of our review at the medical center, management reported that they had entered into negotiations with DHES and anticipated savings of about \$17,000 a quarter (\$68,000 annually).

In addition to reducing costs, contracting for health services can eliminate the appearance of favoritism. When in-home services are provided without a formal contract, the community health nurse generally selects the home health care provider assigned to each veteran requiring services. The nurse may divide the services among qualified providers or may simply select one service which he or she is familiar, without consideration of others.

### **Contracting for Home Health Services Could Save At Least \$1.8 Million Annually**

VHA should issue guidance encouraging medical centers to contract for fee home health care services. The guidance should include a dollar threshold for formal contracting, benchmark data about costs at other medical centers, average costs in each VISN, and average costs nationwide. Such information would be readily available through the consolidation of fee-basis payments in the Denver HAC. We estimate that VHA could achieve savings of at least \$1.8 million by effectively contracting for home health services by individual medical centers. This estimate is

based on the assumption that medical centers with (i) rates near or below the national average of \$70 for a nursing visit and \$56 for non-nursing services would pay no more than their current rates, and (ii) rates well above average would be reduced to no more than 125 percent of the national average. This is a conservative estimate since it does not include savings from rates less than 125 percent of the national average that could be reduced through contracting.

### **For More Information**

- *Detailed information about the audit scope and methodology is provided in APPENDIX I.*
- *Background information is provided in APPENDIX II.*

### **Conclusion**

VHA spends approximately \$31 million annually for home health and home maker services. VHA should encourage medical centers to contract for in-home services and provide guidance for benchmark rates for reasonable charges for such services. By developing guidelines for contracting and promulgating comparative cost data, we estimate that VHA could save at least \$1.8 million annually.

### **Recommendation 2**

We recommend that the Under Secretary for Health improve the cost effectiveness of home health services by:

- a. Establishing guidelines for contracting for such services.
- b. Providing contracting officers with benchmark rates for determining the reasonableness of charges.

### **Under Secretary for Health Comments**

The Under Secretary for Health concurred with qualification in the recommendation.

### **Implementation Plan**

The Under Secretary agreed that contracting for home health services is one way to potentially reduce costs, but also believes that implementation of regulations for payment of outpatient and professional fees using a Medicare-based payment methodology will also accomplish cost reduction goals. The Under Secretary plans to include home health care in VHA's fee-basis pilot project to consolidate authorization and claims processing. Prior to the implementation of the proposed Medicare-based payment methodology, the results of the pilot will be carefully evaluated to determine

the feasibility of applying the system in all Networks. In the interim, VISN Directors will be encouraged to strongly support establishment of contractual agreements for home health care to the fullest extent feasible among their medical facilities. VISN offices will assess levels of home health fee variances among the facilities and assess whether those with negotiated service contracts have achieved notable rate reductions that might be replicated by other facilities. The Under Secretary provided implementation plans with an anticipated completion date of October 1997, with ongoing efforts to introduce additional improvements. *(See APPENDIX III for the full text of the Under Secretary's comments.)*

### **Office of Inspector General Comments**

We consider the Under Secretary's comments and implementation plan to be responsive to the audit recommendation to reduce home health services costs. VHA plans to include payment for home health services in their fee-basis pilot test being conducted in VISN 19. In the interim, VISN Directors will be encouraged to strongly support the establishment of contractual agreements for home health care to the fullest extent feasible among their medical facilities, and to assess the levels of variance among facilities to identify opportunities to enter into negotiated service contracts to reduce costs. According to the Under Secretary's comments, centralization of home health services claims processing to the Denver HAC and using a procedure-based payment methodology similar to Medicare would reduce home health services costs. According to HAC officials, VHA is currently evaluating several potential fee-basis procedures to pay for home health services. While a specific methodology has not been determined at this time, HAC officials have assured us that the implementation of new home health service procedures and rates would result in cost efficiencies by limiting payments to the lesser of either the VAMC's current prevailing rate, or the new fee rate structure.

**OBJECTIVE, SCOPE, AND METHODOLOGY**

**Objective**

The audit was conducted as part of the Office of Inspector General's (OIG) continuing coverage of VHA's fee-basis program to determine if management's internal controls were effective in ensuring that payments were appropriate.

**Scope**

The scope of the audit included fee-basis payments for outpatient and inpatient medical care and home health services provided from April 1 1994 through March 31, 1995. During this period, VHA made 2.2 million payments totaling \$237 million for such services, including \$112 million for outpatient care, \$94 million for inpatient care, and \$31 million for home health care.

The audit included a review of fee-basis payments made for a sample of 280 veteran patients at the following 5 facilities:

- VAMC Columbia, South Carolina
- VAMC Dallas, Texas
- VAMC Lincoln, Nebraska
- VAMC Jackson, Mississippi
- VA Northern California Health Care System

While onsite at the five facilities, we reviewed pertinent administrative and fiscal records including patient payment histories, vendor payment histories, bills submitted by health care providers, records and reports submitted by providers, and authorizations for care. We interviewed responsible VHA employees at VA Central Office and the medical facilities visited, and discussed the results of the audit with VHA management.

Additionally, we reviewed and analyzed nationwide computer matches from the central FEE System in the Austin AC, including potential duplicate payments by two or more VA facilities. We also visited VAMC Atlanta, GA, to gather data on patients paid by VAMC Atlanta and other medical facilities.

## APPENDIX I

We relied on central Fee System data to identify our audit universe. We compared computer-processed data to source documents at 5 VHA facilities and verified that all 280 records reviewed were properly included in our universe. We did not test computer systems controls to ensure completeness of the audit universe. However, our audit conclusions were based on reviews of source documents rather than computer-processed data.

With the exception noted in the above paragraph, the audit was made in accordance with generally accepted government auditing standards and included such tests as were considered necessary under the circumstances.

### **Methodology**

Our methodology consisted of two types of reviews: (i) a random sample of veterans who received fee-basis care paid for by the five facilities we visited (VAMCs Columbia, SC; Dallas, TX; Jackson, MS; Lincoln, NE; and VA Northern California Health Care System) and (ii) nationwide computer matches from the central FEE System at the Austin AC.

While onsite at the five facilities, we reviewed a random sample of a total of 280 patient records to ensure that veterans were eligible for treatment and payments were otherwise appropriate. We also reviewed program management and controls including (i) separation of duties, (ii) access to DHCP, (iii) procedures for ensuring providers were licensed or otherwise qualified, (iv) internal reviews, and (v) compliance with requirements to compare costs of in-house vs. fee-basis procedures.

Our review of nationwide computer matches from the FEE System included (i) veteran patients whose fee-basis treatment was paid through more than one VA facility, (ii) veterans with “date of death” in BIRLS and a subsequent fee-basis treatment date, (iii) fee-basis patients with no social security number in BIRLS, and (iv) patients whose name did not match the social security number in BIRLS.



### **BACKGROUND**

In instances when VA medical facilities are unable to provide specific treatment or cannot provide treatment economically due to geographic inaccessibility, certain veteran patients may be authorized to receive treatment from non-VA health care providers at VA expense. The program of providing such treatment is commonly referred to as the fee-basis program. Fee-basis care may be authorized for inpatient care at a non-VA hospital, outpatient care, and home health care. Outpatient fee-basis care, including home health care, may be authorized for:

- Any service-connected disability.
- Any condition for veterans with service-connected disabilities rated 50 percent or more.
- Certain veterans participating in VA vocational rehabilitation.
- Continuation of care for a nonservice-connected condition treated while a VA inpatient (limited time period).
- Veterans of World War I or veterans eligible for increased pension for being housebound or in need of aid and attendance.

Inpatient fee-basis care may be authorized for:

- Any service-connected disability.
- Any condition of a veteran with a permanent and total service-connected disability.
- Non-service connected disabilities of veterans in Alaska, Hawaii, and the Virgin Islands if otherwise eligible for care in a VA medical facility.
- Disabilities of women veterans otherwise eligible for hospital care if not available at a VA facility.
- Certain veterans participating in VA vocational rehabilitation.
- Medical emergencies of any veteran receiving medical services in any facility over which VA has direct jurisdiction.

During the period of our review, April 1, 1994 through March 31, 1995, VA paid \$237 million for fee-basis services, including \$112 million for outpatient care, \$94 million for inpatient care, and \$31 million for home health care.

## **APPENDIX II**

Payments for fee services were made through 2.2 million individual payment records in the central FEE System at the Austin AC. The central FEE system interacts with the Financial Management System to release payments to medical vendors. Each medical center authorizing care and approving payments under the fee-basis program, uses the fee segment of its DHCP which interacts with the central FEE System. Each medical center is responsible for establishing controls over who may (i) enter authorizations for fee-basis care, (ii) establish medical vendors in the system, and (iii) approve payments.

UNDER SECRETARY FOR HEALTH COMMENTS

Department of  
Veterans Affairs

## Memorandum

Date: May 2, 1997

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Report: ***Audit of Internal Controls Over the Fee-Basis Program***

To: Assistant Inspector General for Auditing (52)

1. This report has been reviewed by VHA program officials, who are in agreement with your conclusion that consolidation of authorizations for fee medical services in each VISN and centralization of payment processing through the Denver Health Administration Center (HAC) will significantly reduce recognized weaknesses identified in your audit. We fully concur in all sections of Recommendation 1 and concur with qualification in Recommendation 2. At this time, we have no basis for disagreeing with your estimate of cost savings. We will provide you with a new savings estimate when our proposed plans are actually implemented. The attached action plan provides a detailed response to each recommendation.
2. We are pleased that you endorse VHA's planned fee-basis pilot project as a positive forward step in both cost savings and improved management controls. Upon completion of the pilot, results will be carefully analyzed and evaluated to determine the feasibility of applying the system in all Network operations. Both the Health Administration Center and VISN 19 (Rocky Mountain Healthcare Network) are committed to insuring that administrative innovations incorporated into the pilot will be successful. As reported in the action plan, sophisticated software capability will replace the current manual fee process to virtually eliminate duplicate payments and payment for services after the death of a veteran. The electronic claims system will also have the capability to provide in writing an explanation of benefits for all transactions for the veteran. The HAC has already established comprehensive internal review procedures for claims processing and training needs are being addressed at all program levels.
3. VHA recognizes that issues identified in the audit must also be dealt with on an interim basis by those facilities not participating in the pilot project. Efforts will therefore be made to address several of the same administrative problems through adjustments in existing software. Staff from the Office of the Chief Information Officer and the Austin Automation Center will coordinate actions to determine the feasibility of introducing additional edits into the Central Fee software to prevent errors in duplicative payments and payments after death. Efforts will also be made to modify letter generation logic to produce letters of explanation for each payment. In

**UNDER SECRETARY FOR HEALTH COMMENTS**

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addition, all VISN Directors and other involved program officials will be kept fully apprised of pilot project activities and proven successes and timely field guidance will be provided on an ongoing basis when indicated.

4. In regard to your recommendations dealing with fee-basis home health care, while we agree that contracting for these services is one way to potentially reduce costs, we also believe that implementation of a Medicare-based payment schedule will accomplish cost reduction goals. The pilot project will apply a Medicare-based payment model and it is anticipated that VHA will eventually adopt the Medicare fee scale. In the meantime, however, all VISN Directors will be encouraged to support establishment of contractual agreements for home health care to the fullest extent possible among their medical facilities. We qualify our agreement with this recommendation because contracting guidelines and establishment of benchmark rates must emanate from the Network rather than from the Headquarters level, as you suggest. Copies of the audit will be distributed to all VISNs, where assessments will be made of home health cost variances among facilities. Based on individual determinations, the VISNs will initiate needed service contracting guidance and work in conjunction with experienced contracting officers to determine benchmarks for reasonable rates, perhaps using the Medicare fee schedule as a basis of comparison.

5. Thank you for the opportunity to respond to this report. If additional information is required, please contact Paul C. Gibert, Jr., Director, Reports Review and Analysis (105E), Office of Policy, Planning and Performance (105).

A handwritten signature in black ink, appearing to read "Kenneth W. Kizer".

Kenneth W. Kizer, M.D., M.P.H.

Attachment

**UNDER SECRETARY FOR HEALTH COMMENTS**

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: OIG Draft Report: ***Audit of Internal Controls Over the Fee-Basis Program***

Report Number: 5R3-297

Date of Report: none

Recommendations/ Actions	Status	Completion Date
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**Recommendation 1**

**We recommend that the Under Secretary for Health ensure that management controls over the pilot project to consolidate fee-basis authorizations and payments to VISN 19 contain provisions to**

**i) prevent duplicate payments**Concur

Under the pilot project, all fee basis authorizations will be processed by the Network 19 Authorization Office (NAO), located at the VAM&ROC, Ft. Harrison, Montana. Payments for authorized services will then be processed by the Health Administration Center (HAC) in Denver. HAC has sophisticated logic written into the claims processing/payment system to prevent duplicate payments. Unlike the current manual fee process, the HAC system conducts an extensive automated duplicate claim check. The system identifies and automatically rejects exact matches. Partial matches are also identified for review by a specialized voucher examiner unit. The full claim, or line items in the claim, can be rejected if it is determined that previous payment was made. If the pilot meets expectations and is implemented nationwide, this requirement for pre-authorization will further help to reduce duplicate payments. In the meantime, however, staff in the Office of the Chief Information Officer will initiate more immediate actions (by June 1997) with the Austin Automation Center to determine feasibility of introducing additional edits into the Central Fee software that will have the capability of rejecting duplicate payments made by multiple medical centers.

Planned                      October 1997 and ongoing

**ii) notify veterans of VA payments for medical care on their behalf**Concur

**UNDER SECRETARY FOR HEALTH COMMENTS**

2. OIG Draft Report: **Internal Controls Over Fee-Basis Programs**

The HAC currently utilizes an electronic claims system that incorporates the COMBO printing solution, a process which provides for the inclusion of the Explanation of Benefits (EOB) in the same envelope as the check. This process will also be applied during the pilot project for all submitted non-VA payments as well as claims that were denied. Both veterans and fee-basis providers will receive an EOB for all transactions associated with a veteran's treatment. In exploring opportunities for additional edits in the existing Central Fee software during the interim period prior to pilot project completion, Chief Information Office and Austin Automation Center staff will attempt to modify letter generation logic to produce letters for all veteran patients utilizing fee-basis services.

Planned

October 1997 and ongoing

iii) **prevent payments for services after the death of a veteran**

Concur

We believe that adequate controls have been incorporated into the pilot project to greatly reduce the potential for this type of payment error. The NAO has already identified specific actions that will be implemented to eliminate fraud. Because a provider is required to call the authorization office to personally request an authorization, opportunity for validation becomes more intensive. In the authorization call, for example, specific questions will be asked to provide confidence that the veteran is alive and authorized care. In many cases, requests will also be made for current care documentation to validate authorizations. NAO will thoroughly educate case managers about pre-screening techniques to eliminate fraud and to recognize certain signals that might suggest questionable circumstances. Furthermore, if the HAC suspects that a veteran has died, all submitted claims will be flagged for review while the status is being confirmed. When the discharge status from an inpatient stay is "deceased," the system is designed to automatically audit claims and search for those that have been filed since the date of death.

As previously reported, coordination between the CIO staff and the Austin Automation Center will soon be initiated to apply edits to existing software. Included among these will be edits to check 'Date of Death' versus 'Service Date' for all payments.

Planned

October 1997 and ongoing

**UNDER SECRETARY FOR HEALTH COMMENTS**

3. OIG Draft Report: **Internal Controls over Fee-Basis Programs**

iv) **conduct meaningful internal reviews**

Concur

HAC has already established comprehensive internal review procedures for claims processing. The new commercial software will have the capability to provide an efficient interface between the NAO and HAC's automated payment system. The system will also provide required information that is timely, meaningful and accurate, thereby assuring a credible data base to support the reviews. Efforts are also underway to establish benchmarks to guide the design and implementation of audits/reviews to assess pilot processes, benefits and savings.

In Process

October 1997 and ongoing

v) **provide appropriate training for the staff**

Concur

Training has been identified as a high pilot project priority and is being addressed at all program levels. The contractor for the new software will provide extensive training on use of the software and internal control capabilities. "Train the Trainer" courses will also be provided for personnel with responsibility for in-house training and system "trouble-shooting." Users have immediate access to on-line help within the system and to customer service representatives during normal business hours. The HAC already has extensive training courses in place that will complement the new NAO system. Cross-training for key personnel will be conducted by both Centers. In addition, training for field staff in the medical centers will be conducted by the NAO at Fort Harrison. Both NAO and HAC are planning to develop and distribute written policy and training materials for additional reference use.

In Process

October 1997 and ongoing

**Recommendation 2**

**We recommend that the Under Secretary for Health improve the cost effectiveness of home health services by:**

**UNDER SECRETARY FOR HEALTH COMMENTS**

4. OIG Draft Report: **Internal Controls Over the Fee-Basis Program**

**a. Establishing guidelines for contracting for such service**

Concur with Qualification

While we agree that contracting for home health services is one way to potentially reduce costs, we also believe that implementation of regulations for payment of outpatient and professional fees using a Medicare-based payment methodology will also accomplish cost reduction goals. During the pilot project, Network 19 will implement the Case Management/Utilization Review Medicare-based model at the NAO. This will hopefully result in better utilization of the Home Health Services Program and case-by-case negotiations can be facilitated. In addition, the pilot program will utilize the Network Acquisitions Service Center (NASC) to provide contracting expertise in an effort to establish formal contracts and elicit competitive bids using established benchmarks.

Copies of this report will be made available to all VISNs. VISN Directors will be encouraged to strongly support establishment of contractual agreements for home health care to the fullest extent feasible among their medical facilities. VISN offices will assess levels of home health fee variances among the facilities and assess whether those with negotiated service contracts have achieved notable rate reductions that might be replicated by other facilities. At the same time, the Director of VISN 19 will fully share experiences of the pilot project with the other VISN Directors on an ongoing basis during regularly scheduled joint meetings. Other involved Headquarters program offices will also be kept apprised of pilot outcomes, and additional guidance will be formulated as successful actions are identified.

Planned

October 1997 and ongoing

**b. Providing contracting officers with benchmark rates for determining the reasonableness of charges.**

Concur with Qualification

As previously reported, upon activation of the pilot project's formal processing by the Network 19 Authorization Office, the current Medicare payment schedule will be utilized to establish universal benchmark rates for fee-basis home health services. If



**UNDER SECRETARY FOR HEALTH COMMENTS**

5. OIG Draft Report: **Internal Controls Over Fee-Basis Program**

successfully applied, the payment schedule will then be implemented by all VHA facilities. In the meantime, as also reported, the VISN offices will assess levels of cost variances among their facilities, encourage expansion of contractual arrangements as indicated, and, if feasible, work with experienced contracting officials to provide guidance about what constitutes limits for reasonable/unreasonable service charges, perhaps using the Medicare fee schedule as a basis for comparison.

Planned

October 1997 and ongoing

## APPENDIX IV

### **MONETARY BENEFITS** **IN ACCORDANCE WITH OIG ACT AMENDMENTS**

**REPORT TITLE:**        Audit of Internal Controls Over the Fee-Basis Program

**PROJECT NUMBER:**    5R3-297

<b><u>Recommendation Number</u></b>	<b><u>Category/Explanation of Benefits</u></b>	<b><u>Better Use of Funds</u></b>	<b><u>Questioned Costs</u></b>
2	Recurring cost reductions by improved contracting for home health care.	\$1.8 million <sup>3</sup>	

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<sup>3</sup> *Estimated annual savings.*

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